STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G141	A. BUILDING _____ B. WING _____	08/05/2011

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METRO HOMES	1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012

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W 000	INITIAL COMMENTS A recertification survey was conducted from August 3, 2011 through August 5, 2011. A sample of three clients was selected from a population of six women with profound intellectual and developmental disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations and interviews with staff and clients in the home and at one day program, as well as a review of client and administrative records, including incident reports.	W 000	Received 9/2/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's qualified mental retardation professional (QMRP) failed to coordinate, integrate and monitor services, for one of the three clients in the sample. (Client #1) The findings include: 1. [Cross-refer to W194.1] The QMRP failed to ensure that all staff assigned to assist Client #1 with her meals in the home received effective training, to ensure implementation of the client's Mealtime Protocol, as written. 2. [Cross-refer to W194.2. and W249] The QMRP failed to ensure that staff in the home and	W 159	W159 1. The staff involved has been disciplined and re trained in this individual's mealtime protocol. The QDDP and the RC/RN will ensure that they monitor the staff during mealtimes at least 2x/week, to ensure that the mealtime protocol is being followed.	8/29/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn L. Shaw	VP - Operations	8/31/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 159	Continued From page 1 at Client #1's day program received effective training to ensure implementation of the client's Mercury Voice output communication device and associated training program. 3. The QMRP failed to ensure effective implementation of the facility's adaptive equipment policies, as follows: A new custom molded seating system was recommended by Client #1's physical therapist (PT) and primary care physician in October 2010. As of August 5, 2011, the client was without the new seating system. a. When interviewed on August 5, 2011, at approximately 9:40 a.m., the QMRP indicated that she had sought the services of three different wheelchair vendors. However, review of Client #1's PT records failed to show evidence of efforts to secure the custom molded seating since October 15, 2010. b. On August 5, 2011, at 10:02 a.m., review of Client #1's Individual Support Plan (ISP), dated December 14, 2010, revealed that it indicated that her wheelchair was "functioning." It made no reference to the Seating and Mobility Assessment, dated October 15, 2010, in which the PT wrote that the seating system "was in disrepair," provided "insufficient support" and "insufficient pressure relief" and was "uncomfortable" for the client. c. On August 5, 2011, at 10:10 a.m., review of QMRP quarterly summary reports revealed that on March 18, 2011, and again on June 17, 2011, the QMRP wrote Client #1's "seating system is	W 159	2. The QDDP has scheduled the communication device training for this individual's day program staff. The Speech/Language pathologist will ensure that staff are trained and are able to implement the program. The QDDP will ensure that she and the Activities Coordinator monitor the staff at least weekly to ensure the program is being implemented correctly. 3. The paperwork to request a new wheelchair has been sent to the Vendor and will be forwarded to Delmarva for approval. The QDDP and Metro Homes will work closely with the DDS adaptive equipment rep. to ensure that a new WC is obtained expeditiously. There will be current documentation and weekly updates to DDS regarding the progress of obtaining this WC. All staff were in serviced on the daily adaptive equipment monitoring form. See attached in service record and WC – paperwork sent to vendor.	

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reported to meet her needs at this time." Neither report made reference to the Seating and Mobility Assessment, dated October 15, 2010, that included the aforementioned problems and the recommendation for a new custom molded seating system.

d. On August 5, 2011, at 11:56 a.m., the QMRP stated that direct support staff used an adaptive equipment checklist to document daily monitoring of the condition of clients' adaptive equipment. At 12:04 p.m., review of the checklist in Client #1's program book revealed that from October 2010 - August 5, 2011, direct support staff routinely reported that no repairs were needed for her seating system, or the arm rest. On August 3, 2011, however, the right arm rest of her wheelchair was observed to be damaged. There was no evidence that the QMRP had verified the accuracy of the staff documentation.

e. Review of the facility's Adaptive Equipment Policies and Procedures on August 5, 2011, at approximately 2:15 p.m. revealed that "The QMRP has the primary responsibility for facilitating the timely repair, modification, or replacement of equipment... Acquisition, repair, modification or replacement of adaptive equipment shall occur within 60 days of the date from when the need was determined... If (replacement)... does not occur within 60 days, the QMRP shall provide written notice to..." the government agency responsible for placements and monitoring of clients in the home. Moments later, interview with the QMRP confirmed that she had not notified the DDS Service Coordinator, to include "reasons for the delay and strategies to obtain resolution," as per the agency's policies

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W 159	Continued From page 3 and procedures. 4. [Cross-refer to W257] The QMRP failed to revise Client #2's tooth brushing program despite the client's poor oral health. 5. [Cross-refer to W445] The QMRP failed to ensure at least one full evacuation during the past certification year to ensure the health and safety of its residents. 7. [Cross-refer to W446] The QMRP failed to establish special provisions to ensure all clients who required wheelchairs for mobility were able to exit the facility safely in the event of an emergency evacuation for three of six residents residing in the facility.	W 159	4. The individual's tooth brushing program has been amended to ensure that her oral hygiene is maintained. All staff have been trained in the new program. 5&6 All staff were trained by Inspector Madison on Fire Safety and Evacuation. There is a written Procedure for the evacuation of the WC individuals if the ramp exit is inaccessible.	
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observations, interviews and record verification, the facility failed to ensure staff demonstrated competency in implementing clients' individual program plans, for one of the three clients in the sample. (Client #1) The findings include: 1. The facility failed to ensure that staff demonstrated competency in implementing Client #1's mealtime protocol, as follows:	W 194	In the future the QDDP and RC/RN will ensure that all staff are trained and monitored and are capable of implementing all programs for the health and safety of the individuals. W 194 1. The staff involved has been disciplined and re trained in this individual's mealtime protocol. The QDDP and the RC/RN will ensure that they monitor the staff during mealtimes at least 2x/week, to ensure that the mealtime protocol is being followed.	8/29/11

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W 194	Continued From page 4 a. Client #1, who was dependent on staff to feed her due to severe contractures of both hands, was observed being fed breakfast in her home on August 3, 2011, beginning at 8:25 a.m. The meal consisted of an English muffin, hard boiled egg and cold cereal, all prepared at a pureed consistency. The direct support staff (S2) feeding her alternated between the food and cranberry-apple juice drink throughout the meal. Client #1 was observed at her day program on August 3, 2011. Beginning at 12:24 p.m., staff fed her lunch which consisted of pureed meat, peas, mashed potatoes and apple sauce. Unlike breakfast observations, day program staff did not offer the client any fluids while she ate. At 1:03 p.m., the day program staff said she would give the client water and a Boost Plus nutritional supplement 30 minutes after she finished her lunch, as per the client's Mealtime Protocol (MP). Review of the MP, dated December 5, 2010, revealed the following instruction: "30 minutes after breakfast: 1 c milk" and "30 minutes after lunch: 1 c fluid." b. On August 5, 2011, at 7:41 a.m., S2 was observed feeding Client #1 her breakfast. At 7:54 a.m., after the client had finished eating her food, S2 gave the client Boost Plus nutritional supplement, using a nosey cup. Review of the same MP, dated December 5, 2010, revealed that the Boost Plus was to be given as a "mid-morning snack," not with her breakfast. On both mornings, S2 failed to implement Client #1's MP, as written. Staff in-service training records were reviewed in	W 194	2. The QDDP has scheduled the communication device training for this individual's residential and day program staff. The Speech/Language pathologist will ensure that staff are trained and are able to implement the communication program effectively. The QDDP will ensure that she and the Activities Coordinator at the day program monitor the staff at least weekly to ensure the program is being implemented correctly. In the future the QDDP and RC/RN will ensure that all staff are trained and monitored and are capable of implementing all programs for the health, rehabilitation and safety of the individuals.	

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the facility on August 5, 2011. At 11:48 a.m., review of staff signature sheets revealed that S2 had received training on mealtime protocols more than 15 months earlier (April 16, 2010). The facility failed to ensure that all staff demonstrated competency in implementing Client #1's mealtime protocol.

2. The facility failed to ensure that staff demonstrated competency in implementing Client #1's communication training program, as follows:

a. On August 3, 2011, at 6:52 a.m., a direct support staff (S2) introduced this surveyor to Client #1, who was seated in her wheelchair in the facility's living room. The client, who was non-verbal, smiled widely when introduced by her staff. She was observed in the home from 6:52 a.m. until 8:48 a.m.

Later on August 3, 2011, at 4:29 p.m., staff in the home presented a communication device to Client #1 as she sat in her wheelchair in the living room. However, there was loud music playing at the time and her communication device was placed on a table. At approximately 4:35 p.m., staff transferred the client to a reclining chair and moments later, a direct support staff (S3) began reading to her from a book. At 4:57 p.m., S3 and another staff transferred the client back into her wheelchair. At 5:37 p.m., S3 wheeled Client #1 to the back hallway to receive her evening medications and at 5:50 p.m., she was wheeled to the dining room table for dinner.

On August 4, 2011, at 10:30 a.m., review of Client #1's individual program plan (IPP) dated December 14, 2010, revealed an objective for

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Client #1 to "use her communication device (Mercury Voice output) to communicate with persons in her environment given assistance as needed." The device had 10 pictures on it, including pictures for "Eat" and "Drink." At no time during the survey were any of the direct support staff observed implementing the client's communication goal.

Staff in-service training records were reviewed in the facility on August 5, 2011. At 11:43 a.m., review of staff signature sheets revealed that staff training on speech programs, communication goals and Client #1's communication device had been provided on March 30, 2009 and March 25, 2010. There was no evidence that the facility provided ongoing staff in-service training to ensure that all staff demonstrated competency in implementing Client #1's communication goal.

b. On August 3, 2011, Client #1 was observed at her day program from 12:15 p.m. until 1:23 p.m. At 12:15 p.m., she was positioned on a beanbag chair. At approximately 12:17 p.m., day program staff transferred the client into her wheelchair and took her to the ladies room to wash her hands. At 12:24 p.m., a direct support staff began feeding her lunch. At 1:13 p.m., the staff asked her if she was full. After gauging the client's facial expressions and body language, the staff stated "you are full, let's go." She then wheeled Client #1 out of the lunch room.

On August 5, 2011, at 1:15 p.m., interview with the QMRP revealed that Client #1's day program would not implement her communication goal without first having their staff receive training on its use. The QMRP further indicated that she

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W 194	Continued From page 7 offered to provide training; however, the day program only wanted the speech/ language pathologist to conduct the training and to date, said training had not occurred.	W 194		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure clients received continuous active treatment, for one of the three clients in the sample. (Client #1) The findings include: On August 3, 2011, at 6:52 a.m., a direct support staff (S2) introduced this surveyor to Client #1, who was seated in her wheelchair in the facility's living room. The client, who was non-verbal, smiled widely when introduced by her staff. She was observed in the home from 6:52 a.m. until 8:48 a.m. On August 3, 2011, Client #1 was observed at her day program from 12:15 p.m. until 1:23 p.m. At 12:15 p.m., she was positioned on a beanbag chair. At approximately 12:17 p.m., day program	W 249	W249 The QDDP has scheduled the communication device training for this individual's residential and day program staff. The Speech/Language pathologist will ensure that staff are trained and are able to implement the communication program effectively. The QDDP will ensure that she and the Activities Coordinator at the day program monitor the staff at least weekly to ensure the program is being implemented correctly. In the future the QDDP and RC/RN will ensure that all staff are trained and monitored and are capable of implementing all programs for the health, rehabilitation and safety of the individuals.	8/29/11

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staff transferred the client into her wheelchair and took her to the ladies room to wash her hands. At 12:24 p.m., a direct support staff began feeding her lunch. At 1:13 p.m., the staff asked her if she was full. After gauging the client's facial expressions and body language, the staff stated "you are full, let's go." She then wheeled Client #1 out of the lunch room.

Later on August 3, 2011, at 4:29 p.m., staff in the home presented a communication device to Client #1 as she sat in her wheelchair in the living room. However, there was loud music playing at the time and her communication device was placed on a table. At approximately 4:35 p.m., staff transferred the client to a reclining chair and moments later, a direct support staff (S3) began reading to her from a book. At 4:57 p.m., S3 and another staff transferred the client back into her wheelchair. At 5:37 p.m., S3 wheeled Client #1 to the back hallway to receive her evening medications and at 5:50 p.m., she was wheeled to the dining room table for dinner.

On August 4, 2011, at 10:30 a.m., review of Client #1's individual program plan (IPP) dated December 14, 2010, revealed an objective for Client #1 to "use her communication device (Mercury Voice output) to communicate with persons in her environment given assistance as needed." The device had 10 pictures on it, including pictures for "Eat" and "Drink." At no time during the survey were any of the direct support staff observed to encourage the client to use her communication device.

This is a repeat deficiency. See Federal Deficiency Report, dated August 20, 2010.

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W 257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's managing staff failed to revise a client's tooth brushing program despite the client's poor oral health. (Client #2) The finding includes: Observation on August 3, 2011, beginning at approximately 4:00 p.m., revealed Client #2's teeth appeared discolored and uneven. Record review revealed Client #2's Dental assessment, dated December 14, 2010, revealed this client was assessed as having "poor oral hygiene." The assessment included: "root tip #25, impacted teeth #5, #1, #16, #17, #32, 'periodontally' compromised #45." Client #2 was provided a second dental assessment on March 23, 2011. This assessment revealed Client #2 was assessed as having severely poor oral hygiene and she had "multiple decayed and impacted teeth that required extraction." Record review on August 5, 2011, at approximately 10:00 a.m., revealed the facility had a tooth brushing program in place dating back to December 2010. The tooth brushing program was scheduled to be implemented for	W 257	W257 The individual's tooth brushing program has been amended to ensure that her oral hygiene is maintained. All staff have been trained in the new program. The nursing staff will ensure that routine dental cleaning is completed at least every 6 mths and all recommendations by the dentist are implemented in a timely manner. In the future the QDDP and RC/RN will ensure that all staff are trained and monitored and are capable of implementing all programs for the health, rehabilitation and safety of the individuals.	8/29/11

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W 257	Continued From page 10 three minutes on each occasion, twice a day and seven days a week. The data collection sheets failed to reflect whether Client #2 tolerated three minutes of tooth brushing as outlined in the plan. Despite Client #2's declining oral health, there was no evidence presented or on file to substantiate that the tooth brushing program was assessed or revised dating back to December 2010. The facility failed to ensure Client #2's tooth brushing program was being assessed and revised to address her poor oral hygiene despite her declining oral health.	W 257		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to furnish adaptive equipment identified as needed by the interdisciplinary team, for one of the three clients in the sample. (Client #1) The finding includes: On August 3, 2011, at 6:52 a.m., Client #1 was observed seated in her wheelchair in the living room. The front and side edges of the foot box on her wheelchair were damaged and the right	W 436	W436 The paperwork to request a new wheelchair has been sent to the Vendor and will be forwarded to Delmarva for approval. The QDDP and Metro Homes will work closely with the DDS adaptive equipment rep. to ensure that a new WC is obtained expeditiously. There will be current documentation and weekly updates to DDS regarding the progress of obtaining this WC. All staff were in serviced on the daily adaptive equipment monitoring form. See attached in service record and WC – paperwork sent to vendor.	9/1/11

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W 436	Continued From page 11 arm rest was worn and torn in numerous areas along a 5-inch long swath. Her body was angled towards the left and there was a notable curve to her back. [Note: Record review later revealed a diagnosis of scoliosis.] The client's head was positioned in a special pillow. On August 3, 2011, at 3:38 p.m., review of Client #1's physical therapy (PT) records revealed a Seating and Mobility Assessment, dated October 15, 2010, in which the PT wrote that the seating on her custom molded wheelchair was "in disrepair," provided "insufficient support" and "insufficient pressure relief" and was "uncomfortable" for the client. He recommended "new custom molded seating only" for her existing wheelchair. A PT assessment dated December 7, 2010, indicated she had been "molded for her new wheelchair on October 15, 2010." On August 5, 2011, at approximately 9:40 a.m., interview with the qualified mental retardation professional (QMRP) revealed Client #1 had not received a new seating system. She said the first vendor had gone out of business and there had been delays in getting another vendor since then. The QMRP presented a 719A form, signed by the primary care physician on September 22, 2010, requesting "new custom molded wheelchair." There was no other 719A form available for review and the client's record did not reflect any recent efforts made to secure the custom molded seating. [Also see W159]	W 436		
W 445	483.470(i)(2)(i) EVACUATION DRILLS The facility must actually evacuate clients during at least one drill each year on each shift.	W 445		

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W 445	Continued From page 12 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure at least one full evacuation during the past certification year to ensure the residents' health and safety, for six of the six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6) The finding includes: Interview with the facility's qualified mental retardation professional (QMRP) and the facility's house manager (HM) on August 4, 2011, at approximately 2:00 p.m., revealed they have not had any full evacuations over the past year dating back from the date of survey. Record review on August 4, 2011, at approximately 2:15 p.m., also failed to provide any evidence that a full evacuation had occurred over the past year. Additional interview with both the QMRP and the HM confirmed that no full evacuation had occurred nor was there any written evidence that any had taken place over the past year.	W 445	W445 All staff were in serviced on Fire Safety and Evacuation by the Fire Marshall. A new evacuation and fire safety plan has been introduced and all staff were in serviced on it. See attached in service record and evacuation plan	8/19/11
W 446	483.470(i)(2)(ii) EVACUATION DRILLS The facility must make special provisions for the evacuation of clients with physical disabilities. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to establish special provisions to ensure all clients who required wheelchairs for mobility were able to exit the facility safely in the event of an emergency evacuation, for three of the six clients residing in the facility. (Clients #1, #4 and #6)	W 446		

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W 446	Continued From page 13 The finding includes: Observation of the facility of August 3, 2011, at approximately 9:30 a.m., revealed the facility had four major points of egress (front door, kitchen door, rear door, basement door). Interview with the facility's qualified mental retardation professional (QMRP) and the facility's house manager (HM) on August 4, 2011, at approximately 2:05 p.m., revealed Clients #1, #4 and #6 always used the "rear door" of the facility during evacuation drills. According to the QMRP and the HM, that was the only egress they used for those clients because it was the only egress with an access ramp. In addition, the QMRP and the HM indicated they had never thought of facilitating any other means for Clients #1, #4 and #6 to exit the facility during fire drills. When asked what procedures would be implemented if the rear exit was inaccessible, the HM and the QMRP indicated they were not sure how they would handle the situation. Record review on August 4, 2011, at approximately 2:25 p.m., revealed there was no written procedure on file at the time of survey to address special provisions for Clients #1, #4, and #6 during an emergency evacuation. Additional interview with the QMRP and HM confirmed there was no written document to address the special provisions for these clients during an emergency evacuation.	W 446	W446 All staff were in serviced on Fire Safety and Evacuation by the Fire Marshall. A new evacuation and fire safety plan has been introduced and all staff were in serviced on it. See attached in service record and evacuation plan	8/19/11

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I 000	INITIAL COMMENTS A licensure survey was conducted from August 3, 2011 through August 5, 2011. A sample of three residents was selected from a population of six women with profound intellectual and developmental disabilities. The findings of the survey were based on observations and interviews with staff and residents in the home and at one day program, as well as a review of resident and administrative records, including incident reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Persons with Intellectual Disabilities (GHPID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, except for the following observations, for six of the six residents of the facility. (Residents #1, #2, #3, #4, #5 and #6) The findings include: On August 5, 2011, beginning at 12:32 p.m., a walk-through inspection of the facility revealed the following: 1. The legs of one of the six chairs at the dining room table were wobbly.	I 090	I090 1. The chairs legs have been tightened. 2. 2. All the debris and litter have been cleaned out. All staff were in serviced on environmental safety and sanitation. The QDDP,RC and QA Manager will continue to complete monthly environmental audits and staff will continue to report safety hazards and unsanitary practices to their QDDP and RC on a daily basis. See attached in service record and Monthly Environmental QA record	9/1/11

Susan F. Sloan — VP Operations — 8/31/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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I 090	Continued From page 1 2. There was a significant amount of litter and debris observed in the front driveway on the first day of survey. The trash remained in the driveway throughout the three-day survey.	I 090		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure adequate administrative staff to effectively meet the residents' needs, for six of the six residents of the facility. (Residents #1, #2, #3, #4, #5 and #6) The findings include: 1. [Cross-refer to I229.1] The qualified intellectual disabilities professional (QIDP) failed to ensure that all staff assigned to assist Resident #1 with her meals in the home received effective training, to ensure implementation of the resident's Mealtime Protocol, as written. 2. [Cross-refer to I229.2. and I422] The QIDP failed to ensure that staff in the home and at Resident #1's day program received effective training to ensure implementation of the resident's Mercury Voice output communication device and associated training program. 3. The QIDP failed to ensure effective implementation of the facility's adaptive equipment policies, as follows:	I 180	I180 1. The staff involved has been disciplined and re trained in this individual's mealtime protocol. The QDDP and the RC/RN will ensure that they monitor the staff during mealtimes at least 2x/week, to ensure that the mealtime protocol is being followed. 2. The QDDP has scheduled the communication device training for this individual's residential and day program staff. The Speech/Language pathologist will ensure that staff are trained and are able to implement the communication program effectively. The QDDP will ensure that she and the Activities Coordinator at the day program monitor the staff at least weekly to ensure the program is being implemented correctly.	8/31/11

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I 180	Continued From page 2 Cross-refer to I500.1. A new custom molded seating system was recommended by Resident #1's physical therapist (PT) and primary care physician in October 2010. As of August 5, 2011, the resident was without the new seating system. a. When interviewed on August 5, 2011, at approximately 9:40 a.m., the QIDP indicated that she had sought the services of three different wheelchair vendors. However, review of Resident #1's PT records failed to show evidence of efforts to secure the custom molded seating since October 15, 2010. b. On August 5, 2011, at 10:02 a.m., review of Resident #1's Individual Support Plan (ISP), dated December 14, 2010, revealed that it indicated that her wheelchair was "functioning." It made no reference to the Seating and Mobility Assessment, dated October 15, 2010, in which the PT wrote that the seating system "was in disrepair," provided "insufficient support" and "insufficient pressure relief" and was "uncomfortable" for the resident. c. On August 5, 2011, at 10:10 a.m., review of QIDP quarterly summary reports revealed that on March 18, 2011, and again on June 17, 2011, the QIDP wrote Resident #1's "seating system is reported to meet her needs at this time." Neither report made reference to the Seating and Mobility Assessment, dated October 15, 2010, that included the aforementioned problems and the recommendation for a new custom molded seating system. d. On August 5, 2011, at 11:56 a.m., the QIDP stated that direct support staff used an adaptive equipment checklist to document daily monitoring of the condition of residents' adaptive equipment.	I 180	3. The paperwork to request a new wheelchair has been sent to the Vendor and will be forwarded to Delmarva for approval. The QDDP and Metro Homes will work closely with the DDS adaptive equipment rep. to ensure that a new WC is obtained expeditiously. There will be current documentation and weekly updates to DDS regarding the progress of obtaining this WC. All staff were in serviced on the daily adaptive equipment monitoring form. See attached in service record and WC – paperwork sent to vendor.	

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I 180	Continued From page 3 At 12:04 p.m., review of the checklist in Resident #1's program book revealed that from October 2010 - August 5, 2011, direct support staff routinely reported that no repairs were needed for her seating system, or the arm rest. On August 3, 2011, however, the right arm rest of her wheelchair was observed to be damaged. There was no evidence that the QIDP had verified the accuracy of the staff documentation. e. Review of the facility's Adaptive Equipment Policies and Procedures on August 5, 2011, at approximately 2:15 p.m. revealed that "The QMRP has the primary responsibility for facilitating the timely repair, modification, or replacement of equipment... Acquisition, repair, modification or replacement of adaptive equipment shall occur within 60 days of the date from when the need was determined... If (replacement)... does not occur within 60 days, the QIDP shall provide written notice to..." the government agency responsible for placements and monitoring of residents in the home. Moments later, interview with the QIDP confirmed that she had not notified the DDS Service Coordinator, to include "reasons for the delay and strategies to obtain resolution," as per the agency's policies and procedures. 4. [Cross-refer to I423] The QIDP failed to revise a resident's tooth brushing program despite the resident's poor oral health. 5. [Cross-refer to Federal Deficiency Report - Citation W445] The QIDP failed to ensure at least one full evacuation during the past certification year to ensure the health and safety of its residents. 6. [Cross-refer to Federal Deficiency Report -	I 180	4. The individual's tooth brushing program has been amended to ensure that her oral hygiene is maintained. All staff have been trained in the new program. The nursing staff will ensure that routine dental cleaning is completed at least every 6 mths and all recommendations by the dentist are implemented in a timely manner. In the future the QDDP and RC/RN will ensure that all staff are trained and monitored and are capable of implementing all programs for the health, rehabilitation and safety of the individuals. 5. All staff were in serviced on Fire Safety and Evacuation by the Fire Marshall. A new evacuation and fire safety plan has been introduced and all staff were in serviced on it. See attached in service record and evacuation plan. 6. All staff were in serviced on Fire Safety and Evacuation by the Fire Marshall. A new evacuation and fire safety plan has been introduced and all staff were in serviced on it. See attached in service record and evacuation plan	

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I 180	Continued From page 4 Citation W446] The QIDP failed to establish special provisions to ensure all residents who required wheelchairs for mobility were able to exit the facility safely in the event of an emergency evacuation for three of the six residents of the facility.	I 180		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observations, interviews and record verification, the facility failed to ensure staff demonstrated competency in implementing residents' individual program plans, for one of the three residents in the sample. (Resident #1) The findings include: 1. The facility failed to ensure that staff demonstrated competency in implementing Resident #1's mealtime protocol, as follows: a. Resident #1, who was dependent on staff to feed her due to severe contractures of both hands, was observed being fed breakfast in her home on August 3, 2011, beginning at 8:25 a.m. The meal consisted of an English muffin, hard boiled egg and cold cereal, all prepared at a pureed consistency. The direct support staff (S2) feeding her alternated between the food and cranberry-apple juice drink throughout the meal.	I 229	I229 The QDDP has scheduled the communication device training for this individual's residential and day program staff. The Speech/Language pathologist will ensure that staff are trained and are able to implement the communication program effectively. The QDDP will ensure that she and the Activities Coordinator at the day program monitor the staff at least weekly to ensure the program is being implemented correctly. In the future the QDDP and RC/RN will ensure that all staff are trained and monitored and are capable of implementing all programs for the health, rehabilitation and safety of the individuals.	8/29/11

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I 229	Continued From page 5	I 229		

Resident #1 was observed at her day program on August 3, 2011. Beginning at 12:24 p.m., staff fed her lunch which consisted of pureed meat, peas, mashed potatoes and apple sauce. Unlike breakfast observations, day program staff did not offer the resident any fluids while she ate. At 1:03 p.m., the day program staff said she would give the resident water and a Boost Plus nutritional supplement 30 minutes after she finished her lunch, as per the resident's Mealtime Protocol (MP). Review of the MP, dated December 5, 2010, revealed the following instruction: "30 minutes after breakfast: 1 c milk" and "30 minutes after lunch: 1 c fluid."

b. On August 5, 2011, at 7:41 a.m., S2 was observed feeding Resident #1 her breakfast. At 7:54 a.m., after the resident had finished eating her food, S2 gave the resident Boost Plus nutritional supplement, using a nosey cup. Review of the same MP, dated December 5, 2010, revealed that the Boost Plus was to be given as a "mid-morning snack," not with her breakfast.

On both mornings, S2 failed to implement Resident #1's MP, as written.

Staff in-service training records were reviewed in the facility on August 5, 2011. At 11:48 a.m., review of staff signature sheets revealed that S2 had received training on mealtime protocols more than 15 months earlier (April 16, 2010). The facility failed to ensure that all staff demonstrated competency in implementing Resident #1's mealtime protocol.

2. The facility failed to ensure that staff demonstrated competency in implementing

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I 229	Continued From page 6 Resident #1's communication training program, as follows: a. On August 3, 2011, at 6:52 a.m., a direct support staff (S2) introduced this surveyor to Resident #1, who was seated in her wheelchair in the facility's living room. The resident, who was non-verbal, smiled widely when introduced by her staff. She was observed in the home from 6:52 a.m. until 8:48 a.m. Later on August 3, 2011, at 4:29 p.m., staff in the home presented a communication device to Resident #1 as she sat in her wheelchair in the living room. However, there was loud music playing at the time and her communication device was placed on a table. At approximately 4:35 p.m., staff transferred the resident to a reclining chair and moments later, a direct support staff (S3) began reading to her from a book. At 4:57 p.m., S3 and another staff transferred the resident back into her wheelchair. At 5:37 p.m., S3 wheeled Resident #1 to the back hallway to receive her evening medications and at 5:50 p.m., she was wheeled to the dining room table for dinner. On August 4, 2011, at 10:30 a.m., review of Resident #1's individual program plan (IPP) dated December 14, 2010, revealed an objective for Resident #1 to "use her communication device (Mercury Voice output) to communicate with persons in her environment given assistance as needed." The device had 10 pictures on it, including pictures for "Eat" and "Drink." At no time during the survey were any of the direct support staff observed implementing the resident's communication goal. Staff in-service training records were reviewed in	I 229		

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I 229	Continued From page 7 the facility on August 5, 2011. At 11:43 a.m., review of staff signature sheets revealed that staff training on speech programs, communication goals and Resident #1's communication device had been provided on March 30, 2009 and March 25, 2010. There was no evidence that the facility provided ongoing staff in-service training to ensure that all staff demonstrated competency in implementing Resident #1's communication goal. b. On August 3, 2011, Resident #1 was observed at her day program from 12:15 p.m. until 1:23 p.m. At 12:15 p.m., she was positioned on a beanbag chair. At approximately 12:17 p.m., day program staff transferred the resident into her wheelchair and took her to the ladies room to wash her hands. At 12:24 p.m., a direct support staff began feeding her lunch. At 1:13 p.m., the staff asked her if she was full. After gauging the resident's facial expressions and body language, the staff stated "you are full, let's go." She then wheeled Resident #1 out of the lunch room. On August 5, 2011, at 1:15 p.m., interview with the QMRP revealed that Resident #1's day program would not implement her communication goal without first having their staff receive training on its use. The QMRP further indicated that she offered to provide training; however, the day program only wanted the speech/ language pathologist to conduct the training and to date, said training had not occurred.	I 229		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by:	I 422		

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I 422	Continued From page 8 Based on observation, staff interview and record verification, the facility's staff failed to ensure that residents' training objectives were implemented in accordance with their Individual Support Plan (ISP), for one of the three residents in the sample. (Resident #1) The findings include: On August 3, 2011, at 6:52 a.m., a direct support staff (S2) introduced this surveyor to Resident #1, who was seated in her wheelchair in the facility's living room. The resident, who was non-verbal, smiled widely when introduced by her staff. She was observed in the home from 6:52 a.m. until 8:48 a.m. On August 3, 2011, Resident #1 was observed at her day program from 12:15 p.m. until 1:23 p.m. At 12:15 p.m., she was positioned on a beanbag chair. At approximately 12:17 p.m., day program staff transferred the resident into her wheelchair and took her to the ladies room to wash her hands. At 12:24 p.m., a direct support staff began feeding her lunch. At 1:13 p.m., the staff asked her if she was full. After gauging the resident's facial expressions and body language, the staff stated "you are full, let's go." She then wheeled Resident #1 out of the lunch room. Later on August 3, 2011, at 4:29 p.m., staff in the home presented a communication device to Resident #1 as she sat in her wheelchair in the living room. However, there was loud music playing at the time and her communication device was placed on a table. At approximately 4:35 p.m., staff transferred the resident to a reclining chair and moments later, a direct support staff (S3) began reading to her from a book. At 4:57 p.m., S3 and another staff transferred the	I 422	I422 The QDDP has scheduled the communication device training for this individual's residential and day program staff. The Speech/Language pathologist will ensure that staff are trained and are able to implement the communication program effectively. The QDDP will ensure that she and the Activities Coordinator at the day program monitor the staff at least weekly to ensure the program is being implemented correctly. In the future the QDDP and RC/RN will ensure that all staff are trained and monitored and are capable of implementing all programs for the health, rehabilitation and safety of the individuals.	8/29/11

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 9 resident back into her wheelchair. At 5:37 p.m., S3 wheeled Resident #1 to the back hallway to receive her evening medications and at 5:50 p.m., she was wheeled to the dining room table for dinner. On August 4, 2011, at 10:30 a.m., review of Resident #1's individual program plan (IPP) dated December 14, 2010, revealed an objective for Resident #1 to "use her communication device (Mercury Voice output) to communicate with persons in her environment given assistance as needed." The device had 10 pictures on it, including pictures for "Eat" and "Drink." At no time during the survey were any of the direct support staff observed to encourage the resident to use her communication device. This is a repeat deficiency. See Federal Deficiency Report, dated August 20, 2010 - Citation W249.	I 422		
I 423	3521.4 HABILITATION AND TRAINING Each GHMRP shall monitor and review each resident ' s Individual Habilitation Plan on an ongoing basis to ensure participation of the resident and appropriate GHMRP staff in revision of such Plans whenever necessary. The schedule for the reviews shall be documented within each IHP. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility's managing staff failed to revise a resident's tooth brushing program despite the resident's poor oral health. (Resident #2)	I 423		

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	HFD03-0104	A. BUILDING _____ B. WING _____	08/05/2011

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I 423	Continued From page 10 The finding includes: Observation on August 3, 2011, beginning at approximately 4:00 p.m., revealed Resident #2's teeth appeared discolored and uneven. Record review revealed Resident #2's Dental assessment, dated December 14, 2010, revealed this resident was assessed as having "poor oral hygiene." The assessment included: "root tip #25, impacted teeth #5, #1, #16, #17, #32, 'periodontally' compromised #45." Resident #2 was provided a second dental assessment on March 23, 2011. This assessment revealed Resident #2 was assessed as having severely poor oral hygiene and she had "multiple decayed and impacted teeth that required extraction." Record review on August 5, 2011, at approximately 10:00 a.m., revealed the facility had a tooth brushing program in place dating back to December 2010. The tooth brushing program was scheduled to be implemented for three minutes on each occasion, twice a day and seven days a week. The data collection sheets failed to reflect whether Resident #2 tolerated three minutes of tooth brushing as outlined in the plan. Despite Resident #2's declining oral health, there was no evidence presented or on file to substantiate that the tooth brushing program was assessed or revised dating back to December 2010. The facility failed to ensure Resident #2's tooth brushing program was being assessed and revised to address her poor oral hygiene despite her declining oral health.	I 423	I423 The individual's tooth brushing program has been amended to ensure that her oral hygiene is maintained. All staff have been trained in the new program. The nursing staff will ensure that routine dental cleaning is completed at least every 6 mths and all recommendations by the dentist are implemented in a timely manner. In the future the QDDP and RC/RN will ensure that all staff are trained and monitored and are capable of implementing all programs for the health, rehabilitation and safety of the individuals.	8/29/11
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure	I 500		

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I 500	Continued From page 11 that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Persons with Mental Retardation), for one of the three residents in the sample. (Resident #1) The findings include: 1. [483.470(g)(2)] The GHPID failed to furnish Resident #1's recommended adaptive equipment, as follows: On August 3, 2011, at 6:52 a.m., Resident #1 was observed seated in her wheelchair in the living room. The front and side edges of the foot box on her wheelchair were damaged and the right arm rest was worn and torn in numerous areas along a 5-inch long swath. Her body was angled towards the left and there was a notable curve to her back. [Note: Record review later revealed a diagnosis of scoliosis.] The resident's head was positioned in a special pillow. On August 3, 2011, at 3:38 p.m., review of Resident #1's physical therapy (PT) records revealed a Seating and Mobility Assessment, dated October 15, 2010, in which the PT wrote that the seating on her custom molded wheelchair	I 500	I500 The paperwork to request a new wheelchair has been sent to the Vendor and will be forwarded to Delmarva for approval. The QDDP and Metro Homes will work closely with the DDS adaptive equipment rep. to ensure that a new WC is obtained expeditiously. There will be current documentation and weekly updates to DDS regarding the progress of obtaining this WC. All staff were in serviced on the daily adaptive equipment monitoring form. See attached in service record and WC – paperwork sent to vendor.	9/1/11

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I 500	Continued From page 12	I 500		

was "in disrepair," provided "insufficient support" and "insufficient pressure relief" and was "uncomfortable" for the resident. He recommended "new custom molded seating only" for her existing wheelchair. A PT assessment dated December 7, 2010, indicated she had been "molded for her new wheelchair on October 15, 2010."

On August 5, 2011, at approximately 9:40 a.m., interview with the qualified intellectual disabilities professional (QIDP) revealed Resident #1 had not received a new seating system. She said the first vendor had gone out of business and there had been delays in getting another vendor since then. The QIDP presented a 719A form, signed by the primary care physician on September 22, 2010, requesting "new custom molded wheelchair." There was no other 719A form available for review and the resident's record did not reflect any recent efforts made to secure the custom molded seating. [Also see I180]

2. § 7-1305.04. Comprehensive evaluation and individual habilitation plan [Formerly § 6-1964]

(c) To the extent of funds appropriated for the purposes of this chapter, each customer shall receive habilitation, care, or both consistent with the recommendations included in the customer's individual habilitation plan.

[Cross-refer to I422] Based on observation, staff interview and record verification, the facility failed to ensure that Resident #1 received training on the use of her communication device, in accordance with recommendations in her Individual Support Plan (ISP), in the home and at her day program.

Health Regulation & Licensing Administration

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R 000	INITIAL COMMENTS A licensure survey was conducted from August 3, 2011 through August 5, 2011. A sample of three residents was selected from a population of six women with profound intellectual and developmental disabilities. The findings of the survey were based on observations and interviews with staff and residents in the home and at one day program, as well as a review of resident and administrative records, including incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and review of personnel records, the group home for persons with intellectual disabilities (GHPID) failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the 7 years prior to the check, for 1 out of 14 direct support staff. (S1) The finding includes: On August 3, 2011, at approximately 3:00 p.m., review of the personnel record for S1 revealed that a Maryland background check had been documented on March 12, 2008. However, her resume indicated that she had been employed in Falls Church, VA from 2005 - 2007 as well as in	R 125	R125 The background check for Va was completed. Metro Homes is in the process of developing a data base and a reminder system which in the future will avert these critical oversights. In the future, the QA department will continue to complete a quarterly HR Audit. See attached – criminal background record	8/31/11

Sharon L. Sloan — VP. Operations — 8/31/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE